HCFA NATIONAL RESTRAINT REDUCTION NEWSLETTER

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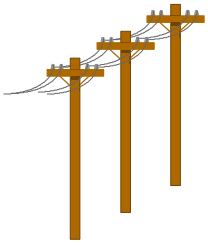
Region III Launches National Initiative

You may not have noticed the change in our masthead (look now!), from "Region III", to "National" Restraint Reduction, but it's there for a reason. On Wednesday, May 8, this Region launched an effort to bring restraint reduction initiatives to every part of the country. The vehicle for this launch was a "Picture -Tel" conference, broadcast to all ten Health Care Financing Administration Regional Offices and our central office, in Baltimore. "Picture-Tel" is a two-way, closed circuit, television medium. It allows the Health Care Financing Administration to present training and information at a fraction of the cost that actual travel would entail. It also enables us to conduct national conferences like the Restraint Initiative on May 8.



Details of the restraint reduction model that we have been developing in conjunction with the Initiatives in Virginia and Pennsylvania were presented during the conference. All Regions were encouraged to work with states in their areas to develop initiatives. Already, we have received feedback from several Regions that have begun initiatives, or are planning for initiatives. Our program was presented by a regional team which included Tim Hock and Peter Goodman, Health Standards and Quality (HSQ) Branch Chiefs, and HSQ analysts and surveyors Joseph Gaffney, Michele Clinton, Peggy Kosherzenko, and yours truly. Team member Michael

Gregory, our resident statistician, presented some of the data we have collected during the Regional initiative. Claudette Campbell, the Associate Regional Administrator for Health Standards and Quality, and also a member of the team, opened the broadcast.

With the cooperation of the Health Care Financing Administration Regions across the country, we hope to see active restraint reduction initiatives in several states. As momentum builds, we believe that the national physical restraint rate, which has been at 20% for several years, and which represents over 300,000 nursing home residents who remain physically restrained in this country, will begin to fall. As we approach the next century, and the millenium, great changes in the social and political landscape of this country are inevitable. One of those changes, we believe, will be the end of the physical restraint of our elderly as a routine practice. Looking back from 2015, physical restraints, we hope, will be viewed as just one more example of the antiquated, primitive practice of medicine in the 20th century.

"Free to Be Me" Workshop Grapples With Chemical Restraints

By Donna Coffmann

Ms. Coffman, R.N., A.C.C., is a candidate this summer for the M.Arts/M.Divinity degrees at Union Theological Seminary in Virginia. She led this workshop for the Crater District Area Agency on Aging in Virginia.

On April 18, 1996, about 75 people gathered in the Family Life Center of the Highland United Methodist Church in Colonial Heights, Virginia, to struggle together with the physical, mental and spiritual implications of using psychoactive drugs as a means of coping with "problematic" behavior of older adults with dementia. The casual atmosphere and interactive presentations allowed the speakers and the audience to work together to develop philosophies and skills that will help eliminate the inappropriate use of drugs as behavior management tools. Local Ombudsmen, state certification and licensure staff, pharmacists, nursing home administrators, social workers, registered nurses, licensed practical nurses, health educators, community services providers, activity directors, lawyers and advocates shared their frustrations and successes in efforts to achieve restraint free care. The participants were led through an exercise that helped examine personal and societal attitudes toward aging and the impact these attitudes have on how we care for older adults with dementia. A shift in paradigm, a new pair of glasses, was suggested as a key step in the success of any approach which would eliminate care practices that inhibit optimal development of emotional and spiritual aspects of frail older adults. A society that values production, physical function, and what a person can do gives little worth to people who are no longer “doers”. “Loss” and “problem” are the operative words of this view. With a new set of lenses, we can regard aging as a “peeling”

process that takes us down to the core of who we really are, human "beings". The operative word for this view is "possibilities".

Dr. Samuel Kidder, Pharmacy Consultant in the Health Standards and Quality Bureau of H.C.F.A. and a lead author of the most recent O.B.R.A. regulations, emphasized a thought that piggy-backed the paradigm shift suggestion. He reminded participants that we must not think in terms of "problematic" behavior, but in terms of behavioral symptoms. These behaviors are generally not "problems" for the older adults with dementia, merely attempts to express unmet needs. Dr. Kidder's quotes for the day were, "Drugs should not disable. They should enable" and "No drugs should ever be given for loss, grieving or boredom." He stressed that it was "criminal" not to rule out physical illness and/or drug toxicity before giving older adults drugs that alter behavior. Behavioral symptoms alone are not sufficient reasons to administer anti-psychotic drugs. We should try everything possible to discover what the unmet need is that is being expressed in the behavior. Dr. Kidder said that we are willing to do this for non-cognitive, non-verbal babies, so why not for non-cognitive, non-verbal older adults? He told participants that drugs used for sleep induction should be used with extreme caution. "Insomnia is not pathological. You will sleep," he stated. He reminded us that with older adults, REM sleep is not as deep and that early morning waking is a sign of depression. Dr. Kidder concluded with saying that everyone in a facility or a family must be educated and trained in caring for older adults with dementia without the use of chemical restraints, even the housekeeping and maintenance staff. He recommended that the manual from Vanderbilt University's work, "Managing Behavioral Symptoms in Nursing Home Residents" which was provided for each participant, be studied and shared in each participant's care giving place.

Welcome to New Readers - Physical Therapists

Since the recent mention of our modest Newsletter in the PT Bulletin , we have been receiving hundreds of requests a day for subscriptions to our publication. This demand is far beyond our ability to meet, so we have worked out an arrangement to publish the Newsletter on the Internet, in the World Wide Web . A lucky 50 or so PTs were added to our direct mail list before we realized the scope of our new readership, so they will receive paper copies. Share a copy with a friend! The WEB address is as follows: http://www.hcfa.gov - go to "publications and forms". The Newsletter will be in two forms - a full version, including all graphics, which can only be read by downloading a program called "Adobe"(PDF); and , for the vast majority of non-techies out there, a text only version for which no special programs are needed (HTML). By the way, our Newsletter comes out about 3 times a year (not "monthly"!), so you won't have to surf the WEB too often. We have saved all the requests for the Newsletter, and we will add them to our mailing list if we gain the ability to print that many copies. For the present, we sincerely hope that most of the PTs who want to read the Newsletter w ill be able to access it on the WEB. The PT Bulletin has agreed to publish the WEB address. We welcome any ideas therapists might have on how they can participate in our national restraint reduction initiative. We especially welcome articles related to our goals from a therapist's perspective. Write us at the address found on the last page of this Newsletter.

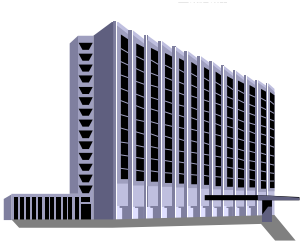
During a working lunch, Woody Hanes, R.N., M. Ed., Executive Director of the Southside Area Health Education Center, brought to our attention that the elimination of the use of restraints as an accepted care practice really begins in the educational process of health professionals. She outlined curriculum that will encourage attitudes and teach skills for compassionate care. Ms. Hanes encouraged participants to advocate for standardized curriculum, which would include skills for restraint free care, for certified nursing assistants who are the front-line care givers in institutions and often in homes.

The afternoon session was facilitated by Sarah Greene Burger, M.P.H., R.N.-C., associate for Program and Policy for the National Citizens' Coalition for Nursing Home Reform. Ms. Burger reminded us that we readily recognize and acknowledge the joyful "symptoms" expressed by older adults with dementia - smiles and laughter. But, we have difficulty recognizing and responding to symptoms of distress. People with dementia are frequently under treated for pain, which is a primary reason for yelling out. Yelling out often leads to the administration of psychoactive (not pain relieving!) drugs. Another key point she emphasized was that people with dementia remain sensitive both to the attitudes and emotions of their care givers, and the "ambience" of their environment. Ms. Burger stressed constructing an environment that is home-like as opposed to one which is based on a medical model. Her slides of a facility in Sweden and the adaptations that were made to accommodate the residents there were inspirational. One of the highlights of the day was a team project where small groups worked together on a self-selected case study to explore behavioral symptoms and come up with ideas to address them, which were then shared with the entire workshop in dialogue with Ms. Burger. Her departing challenge to all was to "Become historians- know every little thing about the person you are caring for!" As "historians" we will be better able to determine the reasons for the behavior of residents and meet their needs.

At the end of a full day of discussion and learning from one another, the majority of participants agreed that we were energized and excited. We were ready to go back to our care giving with a new and renewed vision, and a realization that restraint free care is important for many reasons besides mere "paper compliance" to regulations.

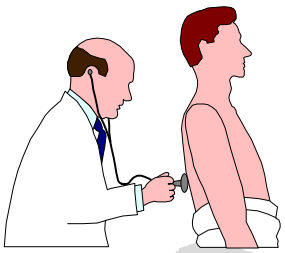
Joint Commission Adopts Restraint Reduction Standards

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has released new standards for restraint use in hospitals, to be effective July 1, 1996.



The restraint standards are part of the new rules which apply to "restraint and seclusion" in hospitals. This direct connection of restraints and seclusion, along with many of the standards

themselves, reflect situations significantly different from what this Newsletter usually addresses: These are incidents involving acutely ill people, often younger and more active than the mostly geriatric population in nursing homes, and sometimes even dangerous to themselves and others. The standards apply to acute hospitals, as well as mental hospitals. Nevertheless, these new standards seem to represent a very significant change in approach to medical care in acute settings, a change which recognizes the principles set forth in the Nursing Home Reform Act, and which should improve treatment outcomes for all patients, including the nursing home residents who have been our primary concern. The Joint Commission now recognizes that "Restraint and seclusion have been highly visible and important areas of concern to patients and providers." Therefore, as the cover letter releasing the new standards states, "These standards address the limitation of restraint and seclusion use to situations with appropriate clinical justification, performance improvement activities supporting reduced restraint and seclusion use, and...creating an environment that... protects the patient's rights, dignity, and well-being."



The introduction to the new standards discusses "creating a physical, social , and cultural environment that...actually reduces their (restraints) use through preventive or alternative strategies (which) helps organization staff focus on the patient's well-being." The standards themselves are much too long and involved to review here, but a few excerpts from those sections most analogous to the nursing home situations we usually write about convey some of the flavor of the new standards:

Standard TX.7.1, which includes subheadings TX.7.1.1 through TX.7.1.1.7, states that "restraint or seclusion use within the organization is limited to those situations with adequate, appropriate clinical justification." As an example of a situation where JCAHO's standards "would apply", the standards describe a hospital unit where "staff raised bed rails at 9 P.M. for all patients . In another unit, bed rails were raised in the evening for all older adults."(emphasis mine) Well, there is probably no one reading this article that hasn't been annoyed or distressed by the seemingly mindless, automatic application of restraints in hospital settings, especially bed rails, to "older adults". Now, finally, perhaps something is being done to end such practices.

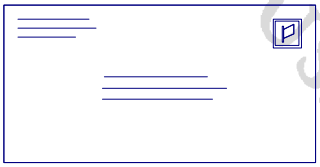
Standard TX.7.1.2 addresses "Performance - improvement activities (which) support limited, and, when appropriate, reduced restraint and seclusion use." This is the restraint reduction standard. This standard begins by noting that "restraint and seclusion are high risk and problem prone." Examples of implementation include one hospital which reduced restraint use in the emergency room. "Staff was able to reduce restraint use through de-escalation

of behavior and the use of accompanying family members." This particular example evokes a picture much more extreme than most nursing home situations - perhaps a violent mental patient, or other potentially dangerous situation. Yet the example relies on understanding behavior, and creating a less threatening environment, strategies not very different from what must be done when a demented nursing home resident is "acting out."

Another example in this section describes the building of a new wing at hospital for "behavioral health programs." Here great effort went into "soft, warm and quiet interiors..." This was designed to "reduce patient stress and agitation and to de-escalate emerging potentially dangerous behaviors." Again, the same principles of a congenial environment decreasing the need for more brutal interventions such as restraints, even in an acute situation, are applied.

No doubt, as we have discovered in long term care, there is a great difference between the introduction of new standards and actual changes in care. After all, we are engaged in a national effort to further reduce restraints nine years after a law was passed limiting their use. Regardless, these standards represent a quantum leap forward in hospital care, with an especially great potential for improving hospital care of the elderly. They also demonstrate that the rejection of the old paradigm, which viewed restraint use as the natural and correct response to a variety of problems, has now become widespread, and that the general acceptance of new paradigm of individualized care is all but inevitable.

The Restraint Reduction Newsletter welcomes your comments. Please send communications to:



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